The challenges of evidence implementation – it's all about the context

Here in the northern hemisphere winter has arrived, whilst those of you in the southern hemisphere are hopefully basking in the delights of summer. As we contemplate the different healthcare challenges we each face, it leads me to dwell on the importance of context and how we ensure that the healthcare we deliver is appropriately tailored to those on the receiving end of this care. Despite the historical and unquestionable positioning of evidence-based practice at the forefront of effective global healthcare, clear gaps between what is traditionally defined as evidence and implementation of this evidence in everyday practice continue to exist. This is a universal issue, not limited to any specific type of healthcare delivery, healthcare profession or country. As the evidence-based healthcare (EBHC) movement evolves, it has been acknowledged that not only knowledge utilization, but the way in which knowledge can be transformed by both individuals and communities into a form that may not mirror the original evidence but suits individual patients, is becoming increasingly important. Exploration, as well as being an essential component of empirical research, is an indispensable human endeavor and we must continue to examine the individual, organizational and contextual factors underpinning effective evidence implementation. The role of evidence in the wider context of healthcare delivery is a topic of considerable interest to practitioners, policy makers, and more importantly, patients and service users at the receiving end of healthcare. There is no "one fits all" answer, as each country and indeed each organization, large or small, where healthcare practice is delivered is influenced by context. Understanding this context is the key to implementing effective change.

Whenever we consider where we are and where we would like to go, it is always important to consider how we got to where we are now. Evidence-based healthcare was initially derived from the concept of evidence based medicine(EBM), a term first proposed by Gordon Guyatt, leader of an international group of clinicians formed to consider results of recent research when treating patients, first appearing in print in 1992 (Evidence based Medicine Working Group 1992).[1] Whilst this initial focus of EBM was on bedside decision-making, the underpinning ideas have been evolving for centuries, with roots in psychology, sociology and philosophy, and a large part of the underpinning vocabulary invented and developed by statisticians and epidemiologists.[2] Similar interest within nursing in a topic labelled "research utilization" had also began in the 1970s when one of the first articles "Adopters and Laggards" was published.[3] Despite waning interest in the 1980s, this field grew rapidly in the 1990s with the development of several research utilization models, often criticized for their focus on individual aspects of implementation and a failure to account for wider organizational issues. A substantive body of work using the BARRIERS scale developed by Funk et al.[4] led the field in identifying common barriers that nurses face when implementing evidence. However, whilst work using this method may be of historical interest to track evolution of attitudes towards evidence in relation to changes in the profession, it is unlikely to determine a way forward for nurse leaders and clinicians.[5] Evidence-based medicine was radically expanded, adopted and adapted under the guise and term of evidence-based practice/EBHC[6] to include all aspects of healthcare rather than being limited to medicine. The term knowledge utilization arose and became popular in the

1990s and is considered a more inclusive term encompassing research, scholarly practice and programmatic interventions aimed at increasing the use of knowledge to solve human problems. Despite all these advances researchers, policy makers and practitioners continue to struggle with the final and arguably the most crucial step in the process, evidence implementation.

Within the last 15 years, researchers have increasingly recognized that despite the efforts of the EBHC movement to reduce the gap between research and practice, robust evidence alone is not enough to facilitate knowledge mobilization within an organization, resulting in a weak relationship between the strength of the evidence base and clinical behavior change.[7,8] As Gabbay and le May[9] argue in their inspirational text, "Clinical Mindlines", not only does this gap still exist despite massive efforts by the establishment, but there is a glaring disparity between policy makers' approaches to promoting EBHC and what social scientists, psychologists and philosophers have long told us about the nature of knowledge and its use in the real world. Authors such as McKillop et al.[10] have argued that approaches to evidence implementation continue to take a push/pull approach with a focus on the nature of evidence, "science push", and on individual implementation behavior, "demand pull", both of which they suggest fail to consistently influence practice decisions as they fail to understand the messy world of health care practice. The translation of research into decision-making and healthcare practice continues to be a challenge with variable uptake of evidence and mixed success of various implementation projects.[11]

Since its inception in 1996, the Joanna Briggs Institute, along with the worldwide Joanna Briggs Collaboration, have made it their mission to promote and facilitate EBHC. A sea of change is underway and whilst the importance of evidence synthesis remains high, there is an increasing focus on meeting the challenges of implementation with the instigation of new tools such as CAN-IMPLEMENT[11]designed to accommodate local needs. I urge practitioners and health providers to continue to experiment and explore with implementation strategies that appreciate the importance of context to achieve the ultimate goal of feasible, appropriate, meaningful and effective healthcare delivery.

Dr Judith Carrier

(Senior Lecturer Cardiff University, Director Wales Centre for Evidence-Based Care-a JBI Centre of Excellence)

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